HSTA
EC-1H
Rev. April 2011

Hawaii Employer-Union Health Benefits Trust Fund

HSTA: Enrollment Form for Active BU 05 & 45 Employees

PLEASE SUBMIT THIS FORM EC-1H TO THE DOE EBU FOR ROUTING

SECTION 1: EMPLOYEE DATA

Please complete all applicable fields below.
Social Security numbers are required to process dependent enrollments.

Name (Last, First, Middle)

_____

Work Phone (_____) _____
Home Phone (_____) _____
Mobile Phone (_____) _____

Residence Address (☐ Check this box if your address has changed)
Street_____
Line 2_____
City_____ State_____ Zip Code_____

Mailing Address (if different from above)
Street_____
Line 2_____
City_____ State_____ Zip Code_____

☐ Open Enrollment

Employee's Social Security Number (SSN) or EUTF ID Number

_____

Gender ☐ Male ☐ Female
Birth Date: (MM/DD/YYYY)

_____/_____/_____

☐ Mid- Year Qualifying Event (describe):

_____

Event Date: _____/_____/_____

Marital Status ☐ Married ☐ Single
Marriage Date: (MM/DD/YYYY)
(☐ Check this box if status change)

_____/_____/_____

Domestic Partnership (DP Status)
☐ IRS Qualified ☐ Not Qualified
DP Date: (MM/DD/YYYY)(☐ Check this box if status change)

_____/_____/_____

Special Note: If your Spouse or Domestic Partner is a State or County Employee or Retiree and is not being enrolled in your plans, please provide his/her SSN:_____

SECTION 2: COVERAGE AND DEDUCTION START SELECTION

If events are filed within 30 days of qualifying event date, some events allow for a selection of the Coverage and Premium Contribution Start Dates. If your event is listed below, please select one of the three options, otherwise skip this section.

Qualifying Events for this Section

Adoption, Birth, Marriage, New Domestic Partnership, Newly Eligible, Placement for Adoption, Reinstatement in Employment, Return from Authorized Leave of Absence (if not currently enrolled)

Available Options for this Section

☐ Coverage starts day of the event & premium contributions start 1st day of the pay period in which the effective date of coverage occurs (if no selection is made, this option will be used).

☐ Coverage & premium contrib. start 1st day of the **first** pay period following event

☐ Coverage & premium contrib. start 1st day of the **second** pay period following event

Completed by DOE ➔ *Effective Date of Coverage:*_____ *Premium Contribution begins:*_____

SECTION 3: PLAN SELECTION

Medical Plan

☐ **Cancel/Waive Medical Coverage**

Choose only one box in each plan section

Type	Carrier Selection	Self	2-Party	Family
PPO	**HMSA** PPO **80/20** Medical and Drug (HMSA), VSP, Chiroplan Hawaii	☐	☐	☐
	HMSA PPO **90/10** Medical and Drug (HMSA), VSP, Chiroplan Hawaii	☐	☐	☐
HMO	Kaiser Medical and Drug, VSP, Chiroplan Hawaii	☐	☐	☐
Supplemental	Supplemental-HMSA Medical, Drug and Vision, Chiroplan Hawaii *	☐	☐	☐
	Supplemental-HDS Dental *	☐	☐	☐

Other Plans

		Cancel/Waive	Self	2-Party	Family
Vision Service Plan (VSP)		☐	☐	☐	☐
Primary HDS Dental		☐	☐	☐	☐
Life	Standard Insurance Company	☐	☐		

For STATE Employees ONLY: Premium Conversion Plan ☐ Enroll ☐ Do NOT Enroll ☐ Change Amount ☐ Cancel PCP

*To be eligible for coverage under any Supplemental Health Benefit Plan, you and your eligible dependent(s) must be covered under another employer group health plan (private/Federal).

The EUTF created new health and life insurance benefit plans for former HSTA VEBA members (BU05&BU45) in response to the December 7, 2010 oral ruling by Judge Sakamoto. The new plans offer former HSTA VEBA members the same standard of coverage in benefits that they enjoyed under their former HSTA VEBA plans and are only available to those who were covered under the HSTA VEBA plans.

SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, DP=Domestic Partner, CH=your Child or your Spouse's Child, DPCH= Domestic Partner's Child, GC=Guardianship/Foster child, DC=Disabled Child if your child is age 19 or over and is also disabled.

Add	Delete	Dependent: Last Name (if different), First Name, Middle Initial	Birth Date (MM/DD/YYYY)	Social Security Number	*Relationship	Gender M / F	Employed Yes / No	Medical	Drug	Dental	Vision
☐	☐		/ /					☐	☐	☐	☐
☐	☐		/ /					☐	☐	☐	☐
☐	☐		/ /					☐	☐	☐	☐
☐	☐		/ /					☐	☐	☐	☐
☐	☐		/ /					☐	☐	☐	☐

Detailed eligibility information is available at www.eutf.hawaii.gov in the EUTF Administrative Rules, Chapter 87A, Hawaii Revised Statutes.

Dependent Certification– See Section 4.6 of "Instructions for Completing Form EC-1" for more information.

I certify that my dependent children meet eligibility requirements for enrollment in the EUTF plans. _____ **(initials)**

I certify that my dependent children, if employed, are not eligible for their employer's medical plan. _____ **(initials)**

Domestic Partner Certification – See Section 4.8 and 4.9 of "Instructions for Completing Form EC-1" for specific instructions.

I have attached all documentation as required in the Domestic Partner Enrollment Instructions. _____ **(initials)**

SECTION 5: OTHER INSURANCE INFORMATION

If you or any of your dependents are covered through another employer's health plan(s), please provide the type of plan, name of the plan, subscriber's name, effective date of the plan, and the health plan coverage (self, two-party, family, etc).

Type of Plan	Name of the Plan (Carrier's Name)	Subscriber's Name	Effective Date	Health Plan Coverage Self	2-Party	Family
			/ /	☐	☐	☐
			/ /	☐	☐	☐

SECTION 6: EMPLOYEE AUTHORIZATION AND SIGNATURE

NOTE: The enrollment of former HSTA VEBA members into these new health and other benefit plans is being done solely to comply with Judge Sakamoto's oral ruling and not to create any constitutional or contractual right to the benefits provided by these plans. Please note that the State does not agree with Judge Sakamoto's ruling and reserves the right to move former HSTA VEBA members into regular EUTF plans if Judge Sakamoto's ruling is overturned or modified.

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand if I do not make a selection or check the "waive" box, it will be considered a "waive." I understand that the benefit elections made on this application are in effect for as long as I continue to meet EUTF's eligibility requirements, or until I elect to change them subject to the provisions of EUTF's plan rules. I have read the benefit materials, understand the limitations and qualifications of the EUTF benefits program and agree to abide by the terms and conditions of the benefit plans selected. I authorize my employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from employee's salary, wages, pension or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages. This form supersedes all forms and submissions I previously made for EUTF coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that I am subject to penalty for perjury.

Employee Signature: _____ Date Signed: _____

Department ID#	Department	Division/School	Bargaining Unit 05 / 45
Date EC-1H Received in Employing Office / /		DOE Phone Number	DOE Fax Number
DOE (or employer designee's) Printed Name DOE (or employer designee's) Signature:			Date of DOE (or employer designee's) Signature / /
Remarks:			